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ON AMPUTATION OF THE THIGH.

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It has been my duty during the past year to direct the treatment of a large number of soldiers who had suffered primary or secondary amputation of large limbs. Some of these cases were received immediately after the performance of the operation; the others after intervals varying from two or three days to as many weeks. An opportunity was thus afforded to observe the effects, in some instances, of neglect, and in others of good treatment, and to compare the results of various operative methods as practised by different surgeons. The study of these cases, followed by a partial review of the history of amputations, has led me to some conclusions which may perhaps be of interest to others.

I propose, therefore, to study some of the general questions connected with the subject of amputation of the thigh, adopting the usual division into circular and flap methods.

CIRCULAR AMPUTATION OF THE THIGH.

Before discussing any of the ordinary methods of operating, it may be profitable to study the very simple case of a circular amputation of the thigh in which all the soft parts are divided by a single sweep of the knife, and the bone sawn at the same level. After such an operation, the end of the stump at once assumes a conical form, from the retraction of the muscles; the muscular fibres which lie nearest to the bone, and which arise from or are inserted into it near its sawn extremity, contract but little, while the longer fibres and muscles, which are farthest removed from the axis of the limb, contract most, drawing with them the cut margin of the skin. This muscular cone soon becomes covered with granulations, which also arise at a later period from the cut end of the bone. As the process of cicatrization advances, the edges of the skin are gradually drawn towards the centre of the stump, and the superficial cells of

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the granulating bone become developed into an imperfect cuticle, which remains always tender, and from its exposed situation is subject to continual abrasions. Often the extremity of the bone exfoliates, after a tedious suppuration, a result much desired by the older surgeons, who were always careful to promote necrosis by the use of the hot iron and of caustics. The legitimate result, then, of such an operation is the miserable failure known as a "conical stump"; granulations form upon the soft parts and begin to retract before they have appeared at all upon the compact tissue of the bone, and the contraction of the cicatrix tends quite as much to draw the flesh away from the bone as to draw the skin towards it.

#### OLD OR "COMMON" CIRCULAR AMPUTATION OF THE THIGH.

The defects of this primitive kind of amputation were early recognized, and attempts were made to preserve enough of the soft parts to cover the end of the bone. This covering may be either of skin, or muscle, or both.

The origin of the practice of saving skin as a covering to the stump, is attributed to Cheselden and to J. L. Petit. These surgeons made first a circular incision of the skin and subcutaneous tissue, which was then drawn upwards by an assistant, or turned over like the cuff of a sleeve. A single sweep of the knife, applied close to the margin of the retracted skin, divided the remaining soft parts, which were drawn upwards by means of a "retractor," and the bone was sawn, as nearly as possible, at the level of the section of the muscles. This was a great improvement, and was at once adopted by English and French surgeons, but it by no means fulfills all the conditions of a good amputation, as I can testify from the study of several cases which I have had to treat. These stumps, a few days after the operation, generally presented a conical mass of retracted and granulating muscle, from the apex of which projected the end of the bone, not yet covered with granulations, and often denuded and dead for perhaps half an inch from its extremity. Surrounding the base of this cone of retracted muscle was the cuff of skin, barely sufficient, when brought together, to cover the end of the muscular mass, leaving the bone either wholly exposed between its lips, or else pressing so hard against the thin covering as to cause much pain, and even sometimes to make its way through by inducing rapid ulceration or sloughing. Even if the lips of the wound had already united by first intention,\* the pressure of the still sharp end of the bone against the skin or new cicatrix threatened to open it again. At the best, the result was very imperfect, for

\* I use this term in the sense in which it is employed by modern writers on surgery, including under it the two processes described by Hunter as "union by first intention," and "union by adhesion or adhesive inflammation," and which are more accurately designated by Mr. Paget by the names "immediate union" and "primary adhesion." In the healing of large wounds it is not easy, practically, to discriminate between these two modes of repair, and it is therefore convenient to retain this expression for the union which takes place prior to and independent of the formation of granulations.

the bone always remained very prominent, even if it became covered by skin, which was seldom the case.

The idea of protecting the end of the bone by preserving a cushion of muscle is as old as the time of Celsus,\* who directs that the bone be separated from its attachments, for some distance above the level of the section of the muscles, and sawn as high as possible. Let us now study the effect of this shortening of the bone upon the progress and nature of the cure. The muscular section assumes, as in the last case, a conical form, owing to the greater retraction of the more superficial muscles, but the end of the bone, instead of forming the apex of the cone, lies buried among the muscles at the bottom of a deep pit or crater. As cicatrization advances, the edges of this crater are gradually drawn outwards towards the skin, whose margins are at the same time being drawn inwards towards the bone. The consequence is, that the crater becomes shallower, but the bone, if it has been cut short enough, and has not been separated from its attachments above the point where it was sawn, will still lie, safe from external injury, at the bottom of a little cavity in the end of the stump.

This precept of Celsus seems to have been forgotten until about the middle of the eighteenth century, when it was revived by Mr. Gooch,† an eminent surgeon of Shottesham, in Norfolk, in England. Gooch commenced his operation by dividing the soft parts, in the manner of Cheselden and Petit, by a double circular incision, but his great improvement consisted in the separation from the bone of the deep muscles and fasciæ to the additional height of about two inches, and sawing the bone at this higher level. Precisely the same operation was described several years later, by Mr. Benj. Bell,‡ who was perhaps the first to distinctly inculcate the principle of "saving as much of the muscular substance of the limb as will completely cover the bone, together with as much skin as will cover the whole surface of the stump."§ Bell states that by this method "the stump is covered with sound skin, as well as with some muscular substance, which admits of the patient resting upon it with freedom";|| and Gooch, in the description of a case, says that "the cicatrix was but a few lines broader than the diameter of the bone, which was left concealed in a little cavity."¶ In the operation of Gooch and B. Bell, the separation of the muscles from the bone was effected by plunging a sharp-pointed knife or scalpel perpendicularly into the face of the stump, by the side of the femur, and carrying it, in the same position, entirely around the bone. In executing this manœuvre there

\* Celsus. *De Medicina.* Lib. vii., cap. xxxiii., *De Gangrena.*

† Cases and Practical Remarks in Surgery, &c. By Benjamin Gooch, M.D. London, 1758. Page 124.

‡ A System of Surgery. By Benjamin Bell. Edinburgh, 1783. Vol. I. p. 301 et seq. on Amputations.

§ Ibid, vol. vi., p. 357.

¶ Ibid, vol. vi., p. 378.

|| Cases in Surgery, p. 126.

is danger of separating the bone unequally from its attachments, and it may easily happen that the bone will be denuded, upon one side or the other, higher than the point where it is to be sawn. From this cause partial exfoliation of the bone may occur, with the effect both of retarding the cure and impairing the final result.\* A better way of effecting the same object is to apply the retractor immediately upon the completion of the circular section of the muscles, and then to divide, in succession, with the edge of the amputating knife, such bridles of tendon or fascia as oppose themselves to the retraction. The chief obstacles to the retraction of the muscles will be found at the back part of the femur, in the aponeurotic tissues which are inserted into the linea aspera; and by dividing these in the manner described, the bone may be denuded to any desirable extent. After a sufficient portion of the bone has been thus exposed, it is well to make a final circular sweep of the knife close to the retractor, so as to divide the periosteum and thus guard against its possible laceration by the teeth of the saw.†

This improved circular amputation, excellent as it is, has still an important defect. The muscles, which are divided in a plane perpendicular to the axis of the limb, immediately retract, and the section, from causes already explained, assumes the form of a cone. It would evidently be better if the cut surface of the muscles were made flat, instead of conical, for the bone would be better protected, and less skin would be required for a covering. This idea was in fact put in execution by the great French surgeon Ambrose Paré,‡ who anticipated the retraction of the muscles by drawing them firmly upwards and holding them there while he made a single circular incision of all the soft parts. The same advice is also given by the distinguished Scotch anatomist and surgeon, Alexander Monro,§ who expressly states that his object is to secure a perfectly flat section of all the tissues of the limb. This flatness of the muscular tissue is most easily, and, at the same time, most surely attained by dividing the deeper layers of muscle twice. After the first section of the muscles, the soft parts are drawn upwards by an assistant,|| and the deeper fibres again divided down to the bone. The retractor is

\* Gooch guarded against this danger by using, in this part of the operation, a knife bent so that the angle of the blade served as a guide to regulate the depth to which it could enter.

† The retractor invented by Gooch and adopted by B. Bell was made of strong leather, which has the great advantage over linen or cotton, that it does not impede the action of the saw by catching its teeth. This is a matter of some importance, for I have seen a surgeon cut the bone half an inch too low, rather than run the risk of getting the teeth of the saw caught in the threads of the retractor. Others have been led, for the same reason, to discard the retractor altogether, at the risk both of leaving the bone too long, and of tearing the flesh by the saw—which, to say the least, produces an unfavorable impression on the minds of the bystanders.

‡ Works of Ambrose Paré. Book xii., chap. xix., on Amputation.

§ Medical Essays and Observations, &c. Edinburgh, 1735. Vol. iv., Art. xxii.

|| The aid of an assistant in this part of the operation is indispensable in amputations performed under the influence of anaesthetic agents. Most of the standard writers on surgery speak of the spontaneous retraction of the muscles at the instant of their division by the knife, but this spontaneous muscular retraction does not occur when the reflex nervous action is suspended by a full dose of ether or chloroform.

then applied, the tendinous attachments at the linea aspera are divided, and the bone is sawn as high as may be thought proper.

This completes the history of one form of the circular amputation in the thigh. The essential points to be observed in its performance are—1st, To preserve skin enough to cover completely the end of the stump, without stretching. This rule is imperative if we hope for a cure by first intention,\* but it need not be so strictly observed in cases where the wound is to be left to heal, from the first, by granulation. 2d, To divide the muscles so as to make the section as flat as possible. This is best effected by dividing the muscles down to the bone by two successive sweeps of the knife, beginning the second cut at the base of the cone formed by the retraction of the outer and longer muscular bundles. 3d, To separate the femur from its attachments at the linea aspera, and to saw the bone so high that it may be completely hidden in the muscles after the removal of the retractor.

In the normal condition of the tissues of the thigh, this operation may be easily and expeditiously performed; the divided integuments are easily retracted to the requisite extent by simply cutting the few bridles of loose connective tissue which tie it down to the fascia, and the muscles are as easily separated from the bone by dividing their attachments at the linea aspera. This operation is, therefore, well adapted to cases of primary amputation for injury, and to such chronic cases as have not been attended with inflammation of the parts in which the incisions are to be made. If, on the other hand, we have to deal with a case in which the limb has become inflamed, we shall find the various tissues so firmly glued together that it will require a laborious dissection to separate them. The skin will no longer slide upon the fascia, but will have to be carefully dissected from it and turned back like a sleeve; the muscles, too, cannot be retracted, at the time of the operation, without much difficulty, but will make up for this by excessive shrinkage at a later period. There is danger, therefore, that the bone may not

\* The skin saved for this purpose need not be in the form of a cuff; in fact, this form is not that best adapted to the formation of a symmetrical stump, for there will always be prominent "ears" of skin at the angles of the wound, which never wholly disappear. The more perfect (i. e. the flatter) the form of the muscular section, the worse does the cuff fit, and the more prominent are the "ears" of skin. It has been proposed to remove the projecting angles at the time of the operation, or what amounts to nearly the same thing, to modify the first incision of the skin by cutting it in the form of semi-elliptical flaps. Sir Charles Bell cut the skin in this form with the edge of the amputating knife, by changing its direction in different parts of the circumference of the limb (see Illustrations of the Great Operations of Surgery, folio, London, 1821). Sédiilot (*Traité de Médecine Opératoire, &c.*, 2me Ed., Paris, 1853, tome i., page 454) made two very thin flaps by transfixing the limb, and completed the section of the soft parts by a circular incision. The most perfect adaptation of the skin to the subjacent cut surfaces may be obtained by fashioning it in the form of either one or two flaps of a breadth equal to or a little greater than the diameter of the limb. If a single flap be chosen, its free extremity must be rounded, and its length should be slightly greater than the diameter of the limb. If, on the other hand, two flaps be made, they must be cut of a rectangular form, and may be either of equal or unequal dimensions, taking care, however, that their united lengths shall somewhat exceed the diameter of the limb. The choice between these different plans must often be decided by the state of the integuments on different sides of the limb, and will therefore depend, in a great degree, upon the nature of the lesion for which the amputation is performed.

be sufficiently protected by the soft parts, and a bad stump may be the consequence. This operation, therefore, answers better for primary than for secondary amputations, and I think it can be shown that for the latter class of cases, another method (the double-flap operation of Vermale) is to be preferred.

The results of this operation, when performed upon a proper class of subjects and with a due regard to the three points above enumerated, are such as leave little to be desired, whether the cure be effected by first intention or by granulation. The end of the stump will be flat, or perhaps slightly rounded, with a central depression corresponding to the end of the bone, and will in most instances be capable of sustaining considerable pressure. The whole stump tapers symmetrically, and is admirably fitted to support the weight of the body in the conical socket of a modern artificial limb. If this method is adopted in cases in which the tissues have become consolidated and adherent to each other from the effect of previous inflammation, it will be easier to dissect up the skin in the form of flaps than of a cuff, and especial care must be taken to retract the muscles strongly, and to saw the bone at the highest possible point above the level of the section of the soft parts.

**CIRCULAR AMPUTATION OF THE THIGH, IN WHICH THE INCISIONS ARE SO MANAGED AS TO GIVE TO THE SECTION THE FORM OF A HOLLOW CONE.**

Larrey and Dupuytren adopted, in the amputation of the thigh and arm, a method by circular incisions which is, nevertheless, so different from the common operation as to demand a special description. Its chief peculiarity consists in the form of the section, which is that of a deep hollow cone,\* of which the cut margin of the skin forms the base, and the end of the bone the apex. This form is the result of several consecutive circular incisions, and is most readily obtained by the method of Dupuytren. An assistant draws up the skin and flesh as much as possible, and the surgeon, by a single circular sweep of the knife, divides all the soft parts nearly or quite to the bone. The cut surface of the muscles at once assumes the form of a cone, at the base of which the knife is again applied, and again carried round the limb, dividing everything to the bone. A third, and, if necessary, a fourth or fifth, circular section of the deepest muscular layers may be made with the greatest rapidity, and the bone is sawn in the track of the last incision. In this way the bone may be sawn as high even as six inches above the first in-

\* Several older surgeons use this expression as applicable to their own operations, but it does not appear that they really attained, or indeed aimed at, anything more than a flat, or at most a slightly concave section of the muscles. Mr. Hey, whose description of his method is nearly identical with that of Larrey, says, in fact, that "the most perfect union of the soft parts would be produced by making an incision through them all in a conical form; but [that] such an incision is impracticable in the ordinary mode of operating, nor is it necessary for the formation of a good stump."—(See *Practical Observations in Surgery, &c.*, by William Hey. 2d Ed., London, 1810, p. 529.)

cision of the soft parts,\* and the extremity of the stump presents the form of a deep conical cavity with the bone at its apex. Larrey† operated in the same manner, with the single exception that in the first incision he divided only the skin and subcutaneous tissue which were retracted by an assistant during the performance of the rest of the operation. Desault‡ made several circular incisions, dividing the soft parts layer by layer, instead of dividing all by one sweep of the knife.

In this amputation, which as simplified by Dupuytren is extremely rapid and brilliant, the nature of the cure will depend almost wholly upon the height above the first incision at which the bone is sawn. If the conical cavity be made too shallow, or if it become so from subsequent shrinking of the soft parts, the operation will approach in character the very imperfect one of Paré; but if, on the other hand, it be of sufficient depth to admit of the coaptation not only of the skin but also of the muscular sides of the cavity, extensive union may take place by first intention or by the adhesion of the granulating surfaces, and the end of the stump will be well rounded, with the bone deeply buried at its centre. It is highly important to know the measurements which will probably ensure this result. The question has been discussed by Sédillot§ who has arrived at the conclusion that the distance between the level of the first incision and that of the section of the bone should be equal at least to three fourths of the diameter of the limb, and may generally be made even greater with advantage. The great danger, particularly in a very long stump, is that the bone will be sawn too low, thus causing much trouble and anxiety in the after-treatment of the case, and ending perhaps in a conical stump. No harm can arise from a redundancy of soft parts, and much evil may result from not saving enough.

The rapid performance of this operation, in the way described, depends, as in the older circular method, upon the lax condition of the subcutaneous and intermuscular areolar tissue; if there has been much inflammation of the limb it will be difficult, if not impossible, to retract the soft parts sufficiently. The principal advantage of this mode of amputating is the facility which it affords for the perfect adaptation to each other, throughout their entire extent, of the cut surfaces both of muscle and of integument; a condition eminently favorable to extensive union by first intention. The sides of the wound are easily brought together, and may be kept in place by a few strips of adhesive plaster, while the deeper muscular surfaces are as easily held in contact with each other by soft compresses placed on opposite sides of the stump and confined by a

\* Dupuytren. *Leçons Orales de Clinique Chirurgicale.* 2me Ed., Paris, 1839, tome 2, page 333.

† Larrey. *Mémoire on Amputation.*

‡ Desault. *Oeuvres Chirurgicales, par X. Bichat.* Paris, 1796.

§ Sédillot. *Traité de Médecine Opératoire.* 2me Ed., Paris, 1853, tome 1, p. 327.

few turns of a roller. Excellent stumps may be made by this method, which, however, except in the manner of its performance, has less resemblance to the ordinary circular, than to the double-flap operation.

#### FLAP AMPUTATION OF THE THIGH.

*Method with two equal Flaps.*—This method was brought forward, at about the same time, by Vermale\* and Ravaton.† As performed by the latter surgeon, it is but a modified circular operation, in which no special covering of skin is preserved, and in which the denudation of the bone is effected by means of two longitudinal incisions upon opposite sides of the limb. In its results it closely resembles the operation of Celsus, with the advantage over it that the bone may be largely denuded with much greater ease, and is therefore more likely to be sawn at a sufficient height above the level of the section of the soft parts. Vermale operated by transfixing the thigh with a long knife, thus cutting the flaps from within outwards. The result is substantially the same as in the method of Revaton, but, from the manner of cutting the flaps, they are more or less rounded and thinned at their free extremities, so as to admit of the margins of the skin being drawn together to form a covering for the end of the stump. In this operation the whole muscular substance of the limb is preserved for several inches below the point of section of the bone; the tissues, of which the flaps are formed, lie in their original position, and in most cases readily adhere to each other, forming a round and fleshy stump; the bone does not incline to protrude beyond the soft parts, because the deepest muscular fibres, which are attached immediately to the femur and therefore retract but little, are preserved of nearly the same length as the superficial muscles; and, finally, there are no angles of skin to form "ears," as in the common circular operation.

The double-flap amputation is generally performed in one of two ways—either by transfixing the limb and cutting the flaps from within outwards, or by cutting them from without inwards. In the operation by transfixion, the point of the knife is plunged at once to the bone, with which it should be kept closely in contact as it is pushed onward in its course through the limb.‡ The knife is then carried downwards with a sawing motion, still grazing the bone, until about half the length of the flap has been cut; the edge of the knife is now to be turned obliquely outwards, and the section completed, thus giving to the extremity of the flap a curved outline. The other flap is formed in the same manner. An inexperienced operator may fail to transfix the limb symmetrically—that is, he may not make the knife come out through the skin at a point exactly opposite to that at which it entered. This is a matter of very little con-

\* Manheim, 1767.

† Paris, 1768.

‡ The object of this direction is to insure the preservation of the deepest muscular fibres, which are of very great importance as a protection for the end of the bone.

sequence, but a beginner may easily guard against it by first marking two dots upon opposite sides of the limb, or he may take the measure of the circumference of the thigh by encircling it equally with the thumb and fore- or middle-finger of both hands, and then allowing the left hand to remain in the same position, as a guide to the knife in the transfixion. Langenbeck\* cut both flaps from without inwards, first grasping with the left hand the tissues from which the flap is to be made. In a double-flap operation, described about the beginning of the present century by Professor Nathan Smith,† of Yale College, the form of the flaps was first marked out in ink, using as a guide a piece of paper cut in the form of a semi-circle, whose radius was equal to a fourth of the circumference of the limb at the point selected for the section of the bone. An incision was made in the course of the lines thus marked out, through the integuments first, which were drawn upwards by an assistant, and then obliquely through the muscles. After the soft parts were thus completely divided, the retractor was applied, and the bone sawn as high as possible between the flaps. In this operation the form of the flaps, owing to the tapering of the thigh, is almost exactly the same as in the method by transfixion as just described, but the separate division and retraction of the skin facilitates the coaptation of the soft parts and diminishes the danger of injurious tension upon the sutures. Another, and by no means the least, merit of this operation is the certainty with which it enables an inexperienced operator to make a good stump. In this operation the length of the flaps must depend in some degree upon the range of contractility of the muscles which enter into their formation, or, in other words, the nearer to the knee the amputation is performed the longer should the flaps be cut. As a general rule, the length of the flaps should be equal to three fourths or seven eighths of the diameter of the limb at the point where the bone is to be sawn. Great care should be taken to preserve the whole thickness of the muscles at the base of the flaps, and not to thin them except in the distal half of their length. The operation by transfixion is the most rapid, and is the one generally to be preferred, but there is no objection to either of the other methods. In cutting from within outwards, a little additional skin may be saved by drawing the integuments gently upwards towards the body before cutting them through. The flaps may be held in pretty good contact with each other by strips of adhesive plaster, but it is better, perhaps, to use a few sutures besides. The direction of the flaps may be varied almost indefinitely, and will sometimes be determined by the nature of the injury; as in the case of gun-shot fracture of the femur, in which the flaps should be so planned as not to include

\* Gottingen, 1820.

† Medical and Surgical Memoirs, by Nathan Smith, M.D. Edited by Nathan R. Smith, M.D. Baltimore, 1831, page 215, et seq.

in them the tissues lacerated by the ball. As a general rule, however, antero-posterior flaps are to be preferred to lateral ones, for in the latter case the end of the bone is in rather close proximity to the anterior angle of the wound, and may even be made to protrude by the action of the psoas-iliacus muscle flexing the femur upon the pelvis. The sciatic nerve is sometimes seen extending nearly to the extremity of the posterior flap; if this happens to be the case, it should be drawn out of its sheath and divided as high as possible, lest it become engaged in the cicatrix and cause a painful or tender stump.

The double-flap operation may be performed with nearly equal facility in all conditions of the tissues, from the state of perfect health, as in primary amputation for sudden injury, to the firm consolidation of the parts which results from the effusion and organization of inflammatory products. In the latter class of cases, therefore, it offers material advantages over any of the approved circular methods, both in ease and rapidity of performance and in the perfection of the immediate result. The form of the wound is favorable to the exact coaptation of the soft parts, whether we hope for union by first intention or by the adhesion of the granulating surfaces. The vascular connections of the flaps are not disturbed, and their nutrition is therefore more perfect than in the case of a cuff or flaps of integument only. The end of the bone is deeply buried between the flaps, but it does not press upon them, for it is protected by the projection beyond it of the deep muscular fibres. The stump bears neglect and bad usage during the after-treatment remarkably well, and will generally turn out well even in the hands of a very unskilful dresser.

[To be continued.]

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#### PUNCTURED WOUND OF THE BRAIN.

[Communicated for the Boston Medical and Surgical Journal.]

CORPORAL John B. Buckley, of Co. D, 62d Reg. Pa. Vols.; enlisted May, 1861, at Sewickleyville, Alleghany Co., Penn.; aged 24 years; former occupation a carpenter; dark complexion, brown hair, blue eyes. General health has always been good. Has been, for several years, in the habit of using tobacco; in every other respect very temperate, never having used, to any extent, intoxicating drinks. Was admitted into the Finley General Hospital, May 9th, 1863, with a wound of the head, received the fourth of the same month, in the battle near Chancellorville, Virginia.

The wound, which was in the eyebrow, over the right eye, presented the appearance of having been inflicted with a bayonet, or some other sharp-pointed instrument, and was found, on examination, to have penetrated the skull through the frontal sinus, and to have taken a course horizontally backwards into the brain. I passed

a straight bougie along the track of the wound into the right anterior lobe of the brain, the distance of four inches, without force, and without the least pain to the patient. He appeared perfectly conscious, and suffered no pain; pulse natural in frequency and strength, and no heat nor febrile excitement whatever. The perforation in the skull would barely admit the point of the index finger, and there were found a few small fragments of bone, which had been driven in, still hanging at its inner side.

I did not think it prudent to continue the examination further. There was no haemorrhage. Perfect quietness was strictly enjoined; a saline laxative was ordered to be given, and cold water dressings applied to the wound. The diet to be light and unirritating; and as but little could be done in the way of treatment, and there being not the least hope of saving the patient, it was thought best to leave the case almost wholly to the powers of nature.

The patient himself was decidedly of opinion that his wound was caused by a ball, and not by bayonet, as he confidently affirms he was not in a charge, and the enemy were not very near when he got injured. It might have occurred accidentally from a bayonet in the hands of one of his comrades. On this point I interrogated him a number of times, and he persistently maintained that his injury was from a ball; but this was disproved on dissection.

May 14th.—It is now ten days since the wound was received, and yet he continues conscious and comparatively comfortable, complaining of but little pain or unpleasant feeling in the head. During the last four or five days he has got up several times and walked about the ward with little apparent inconvenience. Is perfectly calm and undisturbed in mind, although he has been informed as to the almost certain fatal termination of his case. The same temporizing treatment to be continued, and quietude to be observed.

May 16th.—For the last two days he has manifested signs of mental disturbance, and the vision of the left eye, as well as that of the right, seemed in a measure lost; and at times optical illusions annoyed and deceived him. More pain in the head complained of, and thirst for cold drinks very urgent. He is allowed to have whatever he desires, and care is given to make him as comfortable as possible. Bowels have been kept soluble by an occasional dose of magnes. sulph., and the water dressings still employed. Some discharge of pus and cerebral substance from the wound.

About noon, to-day, was taken with a tremulous motion of the hands and arms, and reaching after imaginary objects. Complains of more pain in the head when aroused from a partial stupor into which he had fallen. Skin of natural temperature; pulse varying but little from 80 per minute, and of ordinary strength; moderate incoherence of thought and expression; scenes of the battle-field, friends, home and other things, alternately occupy the mind; in short, all the symptoms point unerringly to a speedily fatal termination.

May 17th.—Was comparatively quiet through the night. Pulse 125 a minute, and less resisting; greater tremulousness of the hands and arms; more picking and reaching after imaginary things; stupor increased; thirst still excessive; no appetite for food; vision nearly or quite extinct; discharge of pus and brain substance the same. In the afternoon, slight convulsions took place; the vital forces gradually sinking. He died at 6 o'clock, P.M., with but little apparent suffering.

*Sectio Cadaveris*, fourteen hours after death. On removing the calvarium, the sinuses of the dura mater and other vessels were found to be highly engorged with blood. The right hemisphere of the cerebrum was sliced off from above downwards. When coming down to near a level with the corpus callosum, a slight prominence over the right lateral ventricle was observed, which, on being punctured, gave vent to a free discharge of pus. By removing another thin slice of brain, the track of the wound was exposed. It was traced from the point of penetration through the anterior lobe, under the right edge of the corpus callosum, opening the right lateral ventricle, and penetrating as far back as the posterior crus of the fornix, which seemed to have sustained injury. This was the extent to which I was able to trace it. The two lateral and the third ventricles were filled with pus; and in making further search for ball, or other foreign substance, as cause of injury, pus was also found in the fourth ventricle, and beneath the cerebellum, around the medulla oblongata. No ball nor other foreign body could be discovered, even after the most diligent search had been made, and the patient must have been mistaken as to the cause of his wound.

This man lived thirteen days after receiving a wound which had penetrated more than half way through one of the hemispheres of the brain from before backwards, the cerebral functions remaining comparatively little disturbed up to within two or three days of his death. As there had been no vessels of any size wounded, and consequently no haemorrhage in the brain, have we not some small reason for the belief, that, if a free discharge of the pus could have been had immediately after its formation, by a sufficient opening placed dependent, he might possibly have recovered?

*Finley Hosp., Washington, D. C.* } LEWIS HEARD, M.D.  
May 25, 1863. } Acting Ass't Surg. U. S. A.

### *Reports of Medical Societies.*

EXTRACTS FROM THE RECORDS OF THE BOSTON SOCIETY FOR MEDICAL IMPROVEMENT. BY FRANCIS MINOT, M.D., SECRETARY.

MAY 11th.—*Abscess of the Kidney.*—Dr. ELLIS showed the specimen, which came from a patient who died in the Hospital under the care of Dr. C. E. Ware. She was a widow, 36 years old, who had suffered

from pain in the region of the kidneys, with general oedema and swelling of the abdomen, for eight months before her entrance. For three months she had palpitation, dyspnoea, vomiting and pyrosis. She was anaemic; pulse 96. There was a murmur with the first sound of the heart, most audible over the mitral valve. Lungs healthy. Micturition normal. Urine pale, turbid, whitish, very albuminous, containing granular casts, to which oil globules were occasionally adherent. The symptoms steadily increased, and the patient died about five months after her entrance into the hospital.

At the autopsy the lungs were found to be extremely oedematous. The pericardium contained more than a pint of serum. The surface of the heart, and portions of the parietal portion of the pericardium, were covered with a fibrinous formation, which in some places was two lines in thickness, and which could be easily raised from the subjacent surface. The orifice of the mitral valve was somewhat narrower than usual. The right kidney was of the usual size. Its cortical substance was extremely pale, and dotted by many opaque, yellowish-white points. On microscopic examination, the few tubuli seen appeared larger than usual, and were lined with well-defined epithelium.

The left kidney was enormously dilated, forming a sac which was subdivided into two principal cavities, between which no communication was found, but they appeared to represent the pelvis of the organ. Arising from them were large, shallow pouches, largely open, and limited by a smooth projecting lip; these were undoubtedly the dilated calices. The inner surface of the superior cavity and pouches was white and smooth; but that of the lower was quite rough and uneven. In the lower part of the latter was a calculus, about three inches in length and two-thirds of an inch in diameter in the middle, from which it gradually diminished in size towards the extremities. It was covered with a smooth, shining and very brittle layer, which resembled a coat of varnish. An examination of it by Dr. White gave the following result:—

The interior of the mass was very loose and friable, and was composed of carbonate of lime, phosphate of lime, and triple phosphate of ammonia and magnesia, mixed with organic tissue and well-formed animal cells. The outer portion or covering consisted of thin, membranous layers of an albuminous or fibrinous character, filled with the above salts, the whole forming a remarkable nacreous glazing or coating to the whole calculus.

The dilated kidney was about eight inches in length. No normal renal substance was seen, it having been converted into a dense, fibrous-looking tissue. No ureter was found.

Connected with the upper cavity, by a large opening, was a large abscess in the cellular tissue beneath it, with rough, irregular walls. The two cavities contained about two pints of pus, and lying beneath the periosteum, raised that membrane, from the diaphragm to the brim of the pelvis. The upper cavity also communicated, by a free opening in its posterior wall, with the sigmoid flexure of the colon, which likewise contained a large quantity of pus.

MAY 11th.—*Malignant Disease of the Humerus.*—Dr. TOWNSEND exhibited an arm which he had removed at the shoulder, and gave the following account of the case:—

"In March, 1862, I was requested to visit, in Roxbury, a boy four

years of age, who had a tumor situated at the lower part of the biceps muscle of the right arm. It was then about the size of a hen's egg. I learned from the parents, that in September, 1860, he had a fall, injuring the arm. The swelling appeared a month afterwards, and when first noticed it was of the size of a hazel-nut. He had, previously to my visit, been seen by the principal surgeons of this city. The tumor was noduled, with numerous large veins spread over it and in its vicinity. It was not painful. An unfavorable prognosis was given, and the opinion expressed that nothing but amputation would arrest the disease. This coincided with the opinion given by the other surgeons. Previously, however, to my seeing him, the child had been taken to New York, and the three leading surgeons of that city consulted, the elder of whom gave a decidedly unfavorable prognosis in the case. One of them flattered the parents with the opinion that it was scrofulous and would disappear, but, at a subsequent consultation, advised tying the artery, and finally, in the last stage of the disease, recommended amputation as the only alternative. The parents afterwards consulted most of the homeopaths of Boston and vicinity, some of whom promised a cure, and at one time, while waiting for the return of one of the latter to his office, he was carried to a noted bone-setter and rubber, who was allowed to see the disease only, but not to touch it. An Electrician was also consulted, but as the battery proved injurious, he advised the application of a poultice, which was continued for two months.

"After an absence of several months in the country, I saw the child again, in December last, and found the tumor very much enlarged and extending towards the shoulder. Amputation was again recommended, but the advice would not be listened to. On the 27th of April last I saw the child again, when I found the tumor measuring fifteen inches in circumference. After a consultation with Drs. Bigelow and Gay, the parents consented, on the first of the present month, to have the limb removed. The father came to the conclusion, after his large experience in this case, 'that it was safer to trust himself in the hands of science rather than of pretension.'

"In performing the operation (amputation at the shoulder-joint), I found it necessary to arrange the flap so as to avoid the cluster of enlarged veins on the front and side of the upper part of the arm. At the suggestion of Dr. Gay, the posterior flap was seized by a pair of polypus forceps before the artery was divided. Only the skin from the deltoid was used, the muscle itself being filled with the disease. The child is doing well."

Dr. HODGES gave the following account of the dissection of the tumor. The tumor, lobulated and of uniform density, extended from the elbow to the shoulder, involving the entire arm, which was about equally enlarged on all sides. In its upper half, and on the inside, the integument was dissected off with facility; in the lower half of the outside it was blended with the disease, and though unchanged in its external appearance, could not be stripped from the lobules to which it had become adherent. The muscles were in part expanded on the tumor, and in part lost in it. The nerves of the brachial plexus were widely separated from each other, and after entering the tumor also became lost in the disease. The axillary vein was stuffed with the disease for a distance of two and a half inches after it left the tumor.

On section the structure was shown to be a homogeneous, lobulated mass, in density and color not unlike the fat of pork. The shaft of the humerus was thickened and its surface covered with a fine stalacitic growth, radiating into the tumor. At one point, and that near the elbow, the osseous tissue was destroyed, and for a distance of three quarters of an inch replaced by a vascular and marrow-like deposit. The entire shaft was implicated in the disease, and the appearances near the neck of the bone seemed to indicate that the growth had originated in the periosteum.

MAY 25th.—*Fœtus with Protrusion of the Membranes of the Brain, Transposition of Viscera, Malformation of the Throat and encysted Disease of the Kidneys.*—Dr. JEFFRIES WYMAN showed the specimen, and gave the following description of it:—

"This fœtus was presented by Dr. R. E. Hodgdon, of West Cambridge, who was the attending physician at the time of birth. The body was thirteen inches in length, and outwardly exhibited the following anomalies, viz.: an additional finger on the ulnar side of each hand, and a toe on the fibular side of each foot; the ears, nose and the mouth had the deformity usually seen in anencephalous fœtuses; the head was about one half the usual size, the cranium was much flattened, and at the hinder fontanelle, through an opening nearly an inch in diameter, protruded the membranes of the brain; these had torn and ragged edges, were infiltrated with coagulated blood, and had the appearance of having formed portions of a ruptured sac; the integuments did not extend beyond the borders of the opening, the torn membranes being covered with a serous surface. The conditions are those of an anencephalous fœtus (*spina bifida* of the head), the brain, however, being only partially arrested in its development.

"The palate was fissured from its middle, backwards, the uvula being on the left side of the fissure, and bi-lobed. The following viscera were transposed: the aorta arched to the right side; the innominate artery arose from the left of the arch, and to the right of it arose separately the right carotid and subclavian; the great cul-de-sac of the stomach was on the right, and the pylorus on the left side; the large lobe of the liver, with the gall-bladder and umbilical vein, were on the left of the middle line; the duodenum did not pass through the transverse mesocolon, this being attached quite low down in the cavity of the abdomen, so that the whole of the small intestine was above it; the cœcum was on the left side, but not so closely held in place as is usual when in its normal position; the descending colon and the sigmoid flexure were on the right side. There was no omentum, and after a very careful search, no spleen was found.

"The heart, the apex of which had the usual direction, offered the following anomalies: the base of the aorta presented forwards, and behind it was the pulmonary artery, as if the heart had been twisted on itself through half a circle; the pulmonary artery divided into two branches of large size, but there was no *ductus arteriosus*; the foramen ovale was largely open, and there was no outlet from the venous auricle except through this foramen, and through this all the blood of both the upper and lower *cavæ* passed from the venous to the arterial side of the heart. The auriculo-ventricular orifice and valves on the arterial side of the heart were normal, and connected with a ventricle from which arose both aorta and pulmonary artery—the former

normally, except that its position was too far forwards, and the latter by a more contracted and fleshy opening, behind and a little to the right of that of the aorta.

"The right or venous ventricle seemed to be wholly wanting, unless a small cavity in the ventricular walls, and connecting with the venous auricle, could be considered as such. When there is merely a deficiency of the ventricular septum, the two auricles open separately into a common ventricle. In the present instance, the only outlet from the venous auricle was through the foramen ovale.

"The kidneys were slightly enlarged and almost wholly transformed into cysts, with only a trace of normal structure.

"The renal capsules were larger than is usual in the anencephalous condition, but smaller than in the normal state. No anomaly is more constant than the coexistence of imperfection of the renal capsules with the condition of the brain just mentioned; if this is complete, or is carried to excess, they are at the minimum of development. The specimen here described is interesting from the fact that the brain is only partially involved, and that the capsules are affected to a corresponding degree."

A malformation in some respects resembling the one here noticed, is described by Dr. J. B. S. Jackson in the printed Records of the Society, Vol. I., p. 66.

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## THE BOSTON MEDICAL AND SURGICAL JOURNAL.

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BOSTON: THURSDAY, JUNE 11, 1863.

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FOURTEENTH ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION.—Through the kindness of Dr. J. C. Dalton, of this city, we are enabled to furnish an abstract of the proceedings of the Association, taken from the reports published in the *Chicago Tribune*. The attendance was large, and comprised delegates from sixteen States and from the Army and Navy. The following were the delegates from Massachusetts: Henry Cutter, Appleton Howe, Edward Barton, James P. Lynde, Ebenezer Stone, P. J. Kendall, B. E. Cotting, John Homans, John C. Dalton, M. D. Southwick, E. P. Abbe, John Green.

The opening session was presided over by the First Vice President, Dr. Wilson Jewell, of Penn. The Chairman of the Committee of Arrangements, Dr. N. S. Davis, welcomed the members to the city of Chicago, and presented a report, explaining why no regular meeting had been held since 1860. The report was adopted. The following programme of exercises was announced.

General Session, from 9 o'clock, A.M., to 1 o'clock, P.M. Afternoon Session, in Sections, from 3 o'clock, P.M., to 6, P.M., in rooms as follows:

Section on Surgery, in Bryan Hall.

Section on Practical Medicine and Obstetrics, in Bryan Hall No. 2.

Section on Anatomy and Physiology, in Methodist Church Block, 3d floor.

Section on Chemistry and Materia Medica, in the Methodist Church Block, 4th floor.

Section on Meteorology, Medical Topography, Epidemic Diseases, Medical Jurisprudence and Hygiene, in Methodist Church Block, 3d floor.

A recess of ten minutes was announced by the Chair, to enable the delegates to select from their number nominating delegates; after which the retiring acting President, Willson Jewell, of Pa., 1st Vice President, delivered his valedictory, which was an able, patriotic and scientific address. On motion of Dr. Sprague, of New York, the thanks of the Convention were tendered for the address, and a copy requested for publication.

**AFTERNOON SESSION.**—Dr. Haswell, of Delaware, read the Treasurer's Report, recommending that only papers of the greatest importance should be published in the transactions, owing to the increased expense of printing and publishing. Expended since last meeting, \$2,579.86. Balance on hand, \$504.21. He also read the report of the Committee on Publication, which was accepted.

Dr. Griscom, of New York, read an account of a remarkable case of diarrhoea adiposa, which has no parallel in medical records.

Dr. D. L. McGugin, of Iowa, from the Committee on Prize Essays, reported an Essay entitled, "An Inquiry into the Physiological and Medicinal Properties of the Veratrum Viride, together with some Physiological and Chemical Observations upon the Alkaloid Veratria obtained from this and other species, by Samuel R. Percy, M.D., Prof. of Materia Medica and Therapeutics, New York Medical College." After commendatory remarks from several members, the Essay was decided to be worthy of publication in the Transactions, and also entitled to the prize—\$100—and it was thus received and disposed of.

The Committee on Nominations reported that they had nominated the following, who were subsequently elected as the officers for the ensuing year:—

*President*—Dr. Alden March, of New York.

*Vice Presidents*—Drs. James Cooper of Delaware, David Prince of Illinois, C. C. Cox of Maryland, and E. S. Carr of Wisconsin.

*Treasurer*—Dr. Caspar Wister, of Philadelphia.

The election of Secretaries was deferred till the place of the next meeting was decided upon.

The newly-elected officers were conducted to their respective positions.

Reports were called for from committees. Dr. D. L. McGugin, of Iowa, Dr. C. C. Cox, of Maryland, made verbal reports, and were continued on committees. Dr. Davis read a communication from Dr. Squibb, of N. York, of the Committee on Practical Workings of the U. S. Law relating to the Inspection of Drugs and Medicines. He was unable to report—continued. Dr. A. K. Gardner's paper "On the Use and Abuse of Pessaries" was presented, and the reading postponed till Wednesday morning. Dr. C. C. Cox, of Maryland, asked and was granted a few weeks to complete his report on "American Medical Necrology"; also continued on same committee for another year.

A letter from Dr. H. I. Bowditch, of Boston, was read, announcing the receipt of \$356 towards the Hunter Memorial, with a list of officers and agents, and on motion the Committee were instructed to forward the amount of funds on hand, and to close the account.

On motion of Dr. Lawson, of Ohio,

*Resolved*, That a committee of one from each State represented in this Association be appointed to inquire into the recent order issued by the Surgeon-General of the United States Army, in which the further supply of calomel and antimony is prohibited, and to report at as early a period as convenient during the session of the Association. Adopted.

Dr. Arnold, of New York, submitted to the Convention his pamphlet on "Medical Provision for Railroads as a Humanitarian Measure, as well as a source of economy to the Companies." Copies of this work (which embraces an account of all that has been accomplished by the profession to the present time) were presented to the members, with the request that, after being read, the subject be brought up for discussion at some period of this session.

Dr. C. C. Cox, of Maryland, offered the following resolutions, with an appropriate introduction, which, after endorsing remarks from several members, were adopted unanimously:—

*Resolved*, That a committee of five be appointed by the Chair to draft a memorial to Congress, asking the enactment of a law by which surgeons in the service of the United States Army may be accorded relative rank in the same.

*Resolved*, That each medical gentleman present be urgently invited to use every proper influence with the member of Congress from his own district, to urge the passage of a law, at the coming session of Congress, favorable to this object.

The Association adjourned to 9 A.M., Wednesday.

WEDNESDAY MORNING SESSION.—A large number of additional members from several States were announced as having arrived and registered their names as delegates, including a large number of the physicians and surgeons of Chicago.

The reports of committees being in order, on motion, that of the Committee on Medical Education was postponed until the afternoon session.

The Committee on Appointments made their report, which, on motion, was accepted. Pending its adoption, it proposing Baltimore, Maryland, as the next place of meeting, considerable discussion arose, various members proposing different places. The member from Maryland advocated the feasibility of appointing the next meeting at Baltimore, as a national measure. It is for the interest of the Association and the country to hold the meeting *as far South as possible*. The effect of holding it at Baltimore would be a healthy one upon that city and its medical interests. Men of wealth and influence would open their doors and extend warm hospitality to the members of the Association. The question finally resolving itself into a choice between Baltimore and New York city, the latter was unanimously voted for as the place for holding the next meeting.

The balance of the report, concerning the officers of the next meeting, committees, etc., was referred back to the committee for reconstruction, rendered necessary by the substitution of New York for Baltimore.

On motion, a committee, consisting of one member from each State, was appointed to investigate and report upon the present, and a better ambulance system in the army of the United States.

A resolution of thanks to Dr. Wilson Jewell, late acting President, for the able and dignified manner in which he has presided over the deliberations of the Association, was unanimously adopted.

A resolution, requiring the appointment of a committee to urge the compulsory vaccination of every person in the United States, was referred to the section on Hygiene.

The report of Dr. A. K. Gardner, of New York, regarding the use and abuse of pessaries, the reading of which was yesterday postponed until this morning, was called up, as next in order, and on motion, the reading of it postponed until next year.

The Committee appointed to prepare suitable resolutions appropriate to the loss of the Association by the death of its late President, the late Dr. Eli Ives, of Connecticut, made their report, which, after a slight amendment, was adopted.

The Committee on Voluntary Communications presented an abstract of a paper by Dr. Andrews, of Chicago, on "Diatheses—Their Surgical Relations," which was read by the author. Approved, and referred to the Committee of Publication.

The meetings of Sections having been abolished, the President appointed as the Committee on Compulsory Vaccination, which had previously been referred to the Section on Hygiene, Drs. Hibbard, of Indiana; Jewell, of Pennsylvania, and Griscom, of New York. The meeting then adjourned until afternoon.

AFTERNOON SESSION.—According to a resolution passed this morning, Dr. D. J. Macgowan, of New York, from China and Japan, was invited to address the Association. He explained to the meeting the professional bearings of his proposed scientific and industrial expedition to the unknown parts of Eastern Asia. Investigation in relation to the history of epidemics, into the *materia medica*, and into the ethnology of those lands, cannot fail to elicit many facts which promise to be of incalculable value to medicine and the collateral sciences. Dr. M. further expressed a hope that the Association would take some measures to induce the Haytien Government to undertake the acclimitization of Cinchona trees (quinine plants). He gave an account of the success of the Dutch in Java, and of the English in India, and fully believes that in St. Domingo these invaluable plants might be readily cultivated, and thus secure additional supplies of this great remedy in fevers.

Dr. Macgowan has been in correspondence with the Haytien Ambassador in Washington, on the subject, and solicits the influence of the profession, in urging the institution of the necessary experiments in those portions of America north of the equator where the soil and climate seem to afford sufficient encouragement.

In the course of his remarks, the speaker gave an account of the standing of

the medical profession in China and Japan, of their medical literature, &c.; also stated the remarkable facts that they have made many discoveries in the use of remedies for certain diseases, in some cases either actually the same or very similar to those discovered and used here.

Dr. C. C. Cox, from the Committee on Medical Education, read an able, scientific paper on the subject, reviewing the past history of the profession in this respect, and the absence of proper attention to the subject. Many valuable suggestions as to needed improvements were also made. After the rendering of this report the Committee submitted the following resolutions, which, after discussion, were adopted :—

*Resolved*, That a thorough preliminary education in English, Latin, mathematics and physics, constitutes an essential pre-requisite to the admission of a student of medicine into the office of a medical preceptor, or as a matriculant of a respectable medical College.

*Resolved*, That the advancement of medical education demands a more extended and symmetrical course of instruction in the colleges, and a more thorough and impartial examination for the degree of Doctor of Medicine than at present prevail.

*Resolved*, That Medical Jurisprudence and Hygiene are highly important branches of medical science, deserving the careful consideration of all medical teachers and schools.

*Resolved*, That all societies for medical improvement—State, District and County—are important auxiliaries to the advancement and promotion of science, and are therefore highly recommended by this body, as valuable levers in the cause of medical education.

The Committee appointed to make a report upon the recent order of the Surgeon-General, prohibiting the use of mercurials and tartarized antimony by the Army Surgical Corps, made a majority report through Dr. Lawson, of Cincinnati, and an entirely antagonistic minority report by Dr. Woodworth, of Indiana. The former strongly favored the use of these remedial agents in the army, and the latter as strongly discountenanced their use there.

The above comprises the first two day's proceedings—all that has been received up to the time of going to press.

**ANNUAL MEETING OF THE MASSACHUSETTS MEDICAL SOCIETY.**—We trust that our readers in this eastern portion of the State will not forget the meeting at Pittsfield, on Wednesday next, and will not neglect this opportunity of returning the repeated visits made to us of late on similar occasions by our professional brothers beyond the Connecticut. Without considering the importance of sustaining the State Society, certainly no pleasanter excursion could be arranged, even by Perham, than a ride at this lovely season of the year from Massachusetts Bay to the extreme western limit of our State. Few who have not visited it, have any true idea of the rugged and diversified character of the glorious highland region of the Berkshire Hills, in the very centre of which, upon the banks of the Housatonic, Pittsfield is seated. The managers of the various railroads leading thither have generously agreed to furnish a return ticket gratis to all members of the Massachusetts Medical Society who exhibit a certificate that they have attended the meeting; so that the matter of expense can hardly stand in the way of the youngest practitioner's attendance. The annual discourse will be delivered by Dr. Morrill Wyman, of Cambridge; and Dr. Henry H. Childs, of Pittsfield, will preside at the dinner, which will be provided by the Berkshire District Society, and will no doubt be a satisfactory specimen of Berkshire hospitality.

The following gentlemen compose the Committee of Arrangements:—Drs. Clarkson T. Collins, Chairman, Great Barrington; C. C. Holcomb, Lee; J. L. Miller, Pittsfield; A. M. Smith, do.; W. W. Green, do.; Geo. C. Lawrence, North Adams; F. A. Cady, Pittsfield. They would feel greatly obliged to gentlemen intending to be present to inform them previously, so that ample accommodation shall be furnished.

Councillors will bear in mind the meeting to be held at the Berkshire Hotel on Tuesday evening.

**RESIGNATION OF DR. BACON.**—We regret to learn that Prof. Bacon has been obliged, on account of ill health, to resign the position of Chemist to the Massachusetts General Hospital, which he has held for a period of nearly twelve years. Few are aware of the true nature or extent of the services he has so quietly performed during this time. The visiting physician or surgeon generously gives an hour or two of his day, for four months in the year, to the Hospital; but he goes away from his visit each day a more experienced man, and with the happy consciousness of having directly relieved human suffering; he knows, too, that hundreds of persons leave the Institution each year bearing him in grateful remembrance, and that the associations formed between himself and the students he meets there are reciprocally beneficial. No such pleasant recompense, however, attaches itself to the labors of the chemist. Dr. Bacon has undoubtedly devoted more hours of labor to the Hospital during his connection with it than any of the visiting physicians and surgeons for the same length of time—hours, too, spent in solitary, monotonous labors, which could scarcely be of any benefit to himself. We make this comparison solely for the purpose of placing his services, which can be properly appreciated only by those whom his labors have aided in diagnosis, in their proper light. The trustees and friends of the Hospital must certainly feel grateful for having for so long a period had the benefit of the gratuitous and important services of a gentleman so distinguished in medical chemistry. We trust that he may soon regain his health, and long continue to occupy his present professorship in the University.

**VITAL STATISTICS OF BOSTON.**  
FOR THE WEEK ENDING SATURDAY, JUNE 6th, 1863.

DEATHS.

					Males.	Females.	Total.
Deaths during the week	-	-	-	-	28	30	58
Ave. mortality of corresponding weeks for ten years, 1853—1863,					37.4	32.5	69.9
Average corrected to increased population					00	00	76.95
Death of persons above 90	-	-	-	-	0	0	0

*Mortality from Prevailing Diseases.*

Plutosis.	Croup.	Scar. Fev.	Pneumon.	Variola.	Dysentery.	Typ. Fever.	Diphtheria.
9	3	5	2	1	0	1	3

**COMMUNICATIONS.**—Papers have been received from Dr. H. R. Storer, Dr. Cady of Pittsfield, and Dr. Nourse of Bath, Me.

**MARRIED.**—In Melrose, June 4, Joseph Robbins, M.D., of Quincy, Ill., to Miss Louisa A. Norris, of Melrose.

**DIED.**—In camp, near Falmouth, Va., Neil K. Gunn, M.D., Assistant Surgeon of the 1st Mass. Reg't. The deceased belonged to Inverness, Cape Breton, and graduated at the Mass. Medical College in March last, having been in the service only about two months at the time of his death.

**DEATHS IN BOSTON** for the week ending Saturday, noon, June 6th, 58. Males, 28—Females, 30.—Abscess of liver, 1—accident, 1—apoplexy, 2—inflammation of the bowels, 1—congestion of the brain, 1—bronchitis, 1—burns, 1—cancer, 1—consumption, 9—convulsions, 1—croup, 3—diphtheria, 3—dropsey of the brain, 2—scarlet fever, 5—typhoid fever, 1—gastroitis, 1—disease of the heart, 3—intemperance, 1—intussusception, 2—inflammation of the lungs, 2—marasmus, 2—measles, 1—pharyngitis, 1—pleurisy, 1—premature birth, 1—pulmonary apoplexy, 1—smallpox, 1—teething, 1—thrush, 1—unknown, 5—whooping cough, 1.

Under 5 years of age, 24—between 5 and 20 years, 3—between 20 and 40 years, 18—between 40 and 60 years, 6—above 60 years, 7. Born in the United States, 40—Ireland, 14—other places, 4.